Society Reports.

PHILADELPHIA NEUROLOGICAL SOCIETY.

Stated Meeting, December 26, 1893.

President, Dr. CHARLES K. MILLS, in the chair.

Dr. FRANCIS X. DERCUM exhibited

A CASE OF SCLERODERMA OF TRAUMATIC ORIGIN.

The patient whom I have here is one of great interest as the affection is exceedingly rare. Last August this man, while working in a stooping position, was struck on the head by a piece of ice weighing sixteen pounds which had fallen a distance of ten feet; he was rendered unconscious and brought to the Jefferson Hospital. There was a transverse lacerated wound over the occiput which was sewed. The wound did well surgically, but the man himself did not do well. He gradually became more and more neuræsthenic and had persistent pain in the neighborhood of the scar. He has also general headache and backache and some tenderness over the spine.

In addition to the symptoms of general neuræsthenia, we noticed four weeks ago (what the patient had observed two weeks earlier), a curious condition of the skin. The skin about the arms, shoulders and neck began to feel very tense and puffy. Dr. Cantrell has studied the case with me and the condition of the skin has steadily became more marked as we have watched the case. The case is evidently one of scleroderma. This affection in a number of instances has followed nervous shock. In the minds of dermatologists, scleroderma is at present closely associated with morphœa and hemifacial atrophy. The later condition we are pretty certain from one or two post-mortems is due to descending degeneration of the motor root of the fifth nerve, In this class of cases we evidently have to do with a tropho-neurosis.

Dr. J. ABBOTT CANTRELL showed

A CASE OF MORPHŒA OF TRAUMATIC ORIGIN.

Dermatologists look at these cases as two varieties of one disease. One is the diffuse or œdematous form and the other the circumscribed or atrophic form. I have brought this case because Dr. Dercum intended to report his case of diffuse scleroderma and because, as in his case, there is also a history of traumatism. This child while playing at school fell and hit her head on the sharp edge of a desk. There was no rupture of the parts. There was swelling and the consequent œdema following such accidents, and the atrophied condition which you see began immediately afterwards. The injury dates back about eighteen months. This is the form which in the books is called morphœa. In this case it affects the right side of the head extending down towards the external canthus of the eye.

Dr. CHARLES K. MILLS.—In the first case it seemed to me that the pathological condition probably involved the subcutaneous tissue as well as the skin; in other words, we may have not only scleroderma, but a myxœdemoid condition.

The second case can be readily explained on the theory of traumatism involving the motor and trophic branch of the fifth nerve in the particular locality where the affection began. I have seen several cases of hemiatrophy of the face. I believe that in all these cases there is involvement of the muscles supplied by the fifth nerve. I might call attention to a paper by Montgomery that appeared in the *Medical News* during the past year on unilateral facial hypertrophy.

Dr. JAMES HENDRIE LLOYD.—I showed before this Society, about a year ago, photographs of a case of scleroderma or hemifacial atrophy, beginning well up on the vault of the cranium, running down the median line of the forehead and involving the root of the nose, running down also under one eye. In my case, however, there was no history of trauma. The patient was a young Swedish woman at family service. There was no atrophy of the muscles, nothing but this localized area of atrophy.

Dr. THEODORE DILLER, Pittsburg.—My experience ith myxœdema is limited to two cases, the second of which I saw only a short time ago. In examining Dr. Dercum's case, the question arose in my mind: in what respect does this skin-thickening differ from that which is seen in myxœdema? Another query that arose was: might not this possibly be the beginning of myxœdema? I simply raise these questions with the hope that Dr. Dercum will consider them in any further remarks that he may have to make.

Dr. FRANCIS X. DERCUM.—I dismissed the idea of myxœdema on account of the absence of other symptoms—the absence of the spade-like hands which are among the earliest signs of true myxœdema. The face was not affected early. I had the opportunity of seeing the man before the condition came on and have seen him frequently since. Lastly, the case has followed the history of scleroderma which usually begins over the back of the neck and extends to the trunk and limbs.

Dr. Cantrell's case is of exceeding interest because it looks as though the blow might have given rise to some direct nerve injury and the atrophy might be looked upon as the result of that. If this is the proper explanation it is curious that these conditions do not more frequently follow nerve injuries.

Dr. C. S. POTTS exhibited a patient with

HALLUCINATIONS OF SIGHT, TOUCH, TASTE AND SMELL. (See page 178.)

The patient stated that in January, after he had seen Dr. Potts, he passed into a condition of profound stupor from which he was aroused only by severe shaking and loud calling. This condition continued from the last of January until the fifth day of March. The latter part of February he was removed to the asylum. At the end of March he was discharged from the asylum.

The patient then retired.

Dr. H. R. SPRUANCE, of Wilmington.—In regard to the attack of unconsciousness to which the patient has referred the family give a different history. While he says that he was asleep, his family state that at one minute he would be so weak that he could not move, the next he would pick up his wife and carry her, and at times it required two or three men to hold him down. He was taken to the Delaware State Hospital for the Insane. There he was treated with tincture cinchonæ comp. and syrupi pruni virgin., and got somewhat better, ordered by Dr. Richardson now Superintendent at Norristown, under whose care he was, before he was sent to the hospital. He had a nurse with him at night constantly for one week, but says he has not yet seen that nurse.

He describes one of these objects as red, pushing a red hot iron around the room and across the bed and with an explosion coming down and lighting on him. Others are red and white.

Dr. JAMES HENDRIE LLOYD.—The French authors say that the reason that the English and Americans do not have hysteria is because they do not diagnose it. The longer I live and the more I see of the practice of medicine, the more am I convinced of the accuracy of this remark. There is but one disease that will produce the lethargy such as has been described in this case. There is no disease except the grand hysteria that will do this. That lethargy is one of the most marked psychical stigmata of the grand hysteria. I do not know of any other condition that will produce a lethargic state for four or five weeks in a healthy man unless it is hysteria in one of its major manifestations.

In *Brain*, Hitzig, of Halle, one of the most eminent experimenters in Germany, has put on record a case of remarkable lethargy occurring in a workman twenty years of age, following extensive injury to the head and arms. This lethargy presented a periodical aspect. The man would lie for thirty-eight or forty hours in the lethargic state, all the time losing weight and the specific gravity of the urine running down, the nitrogen being decreased. In other words, showing the peculiar alteration in nutrition which has been described by Tourette and Cathelineau, this being preceded by hysterical prodromes. The paroxysm would pass off, to recur in nine or ten days. This had continued for several months when the man came under Hitzig's care and was hypnotised and cured.

This lethargy is always associated with intervallary stigmata. I suspect that this man, if carefully examined, would have shown some of these stigmata. There might have been found some alteration in sensation, probably some areas of anæsthesia, or some narrowing of the visual fields. He has a vision of red and probably has preservation of the red field which the French for the last twenty years have been talking about as one of the most common visual stigmata of hysteria.

Charcot has described one peculiar characteristic of the grand hysteria which he named zoöpsia, the hallucination of the sight of animals. This is seen in a minor degree in many cases of hysteria. I have, however, never seen or heard of a case where this was so marked as in this instance. Considering the zoöpsia, considering the lethargy and considering the slight tremor of his hand which is distinct, I have very little doubt in my own mind that this is one of the major states of grand hysteria, one of the aberrant, atypical forms which we see not infrequently if we look for them.

There are, it is true, certain sensory hallucinations in the insane. I do not think that this case can be included among these. A few years ago, I saw at the Philadelphia Hospital a colored man in an advanced stage of senile paresis. He had the hallucination that he was covered with a serpent's skin with two holes for the eyes, one for the mouth and another to urinate through. This general cutaneous hallucination we see in senile paresis. The present case is advanced in years, but presents no evidence of insanity. I do not think that we can hesitate as to the diagnosis.

Dr. THEODORE DILLER, of Pittsburg.—I might, in this connection, relate two cases of lethargy which have recently come under my observation. A colored boy, 14 years of age, went to Washington three years ago, and while there got into a fight and was struck on the back part of the head with a heavy iron bar. A wound three or four inches in length was produced. He was rendered unconscious for a few mintues. The wound healed and he was apparently well for six months. It was not thought a fracture had been produced. Then he had an attack of lethargy which was frequently repeated. He got stupid and heavy and would lie in bed for eight days, passing the urine and fæces in bed and taking scarcely anything to eat. In fact, the case was almost like that one reported by Professor Hitzig. These attacks recurred every four weeks and always lasted precisely eight days. After this had gone on for two years he returned to Pittsburg and came under my observation. I found concentric contraction of the visual fields, and some anæsthesia and great susceptibility to hypnotism and concluded that he was an undoubted case of hysteria. A full account of the case will appear in the next number of *Brain*.

The second case was a very extraordinary one of hysterical motor aphasia and lethargy. The man came under my observation two months ago. Mentally, he seemed stupid and child-like, but that, I imagine, was his usual condition. He stated that his voice would suddenly leave him and then come back. These attacks would occur every two or three days and would continue from three to six hours. During this time he would be perfectly conscious and be able to understand conversation, recognize objects and think of the words that he wished to use and write them.

Clinically, we would say, that this was a case of motor aphasia; but from the fact that the attacks came on suddenly and disappeared and reappeared suddenly, there would be *a priori* reason for thinking that the case was one of hysteria. On examination, I found general blunting of sensation all over the body, but now special spots of anæsthesia. There was concentric contraction of both visual fields. A month later I found him in the insane asylum. There he had no attacks of motor aphasia, but was having attacks on alternate days, lasting two or five hours in which he would be apparently unconscious, and from which he could not be roused. I have no doubt that these are attacks of lethargy. This man possesses great faith and has experienced great comfort from blessings received at convents. A strong suggestion followed up on several occasions caused these attacks of lethargy to disappear. The man is now brighter and improved in every way.

I must agree with Dr. Lloyd that lethargy is a hysterical manifestation. I know of no other affection of which it is a symptom, and it can scarcely be regarded as a disease in itself.

Dr. JOHN K. MITCHELL.—In spite of the arguments that have been advanced, I am not convinced that this case is hysterical. If, on examination, it were shown that he had narrowing of the visual fields and reversal of the color fields, I, perhaps, should think that this was a hysterical condition. Still, it seems curious that it has not been mentioned that so many of the cases of delusions of uncleanness take the form that they are covered with animals. I have had for a year an insane woman under my care who has the delusion sometimes that she is covered with black insects and sometimes with caterpillars. She will pick them off and throw them on others. We have gotten rid of the insects for two weeks at a time by the subjective measure of scrubbing with oil. This woman has only two delusions, the one of uncleanness and another that her husband has lost his money and they must pull the house down. In some respects she is perfectly sane. In my opinion this patient presented is in the early stages of insanity and will grow worse as time goes on.

Dr. JOSEPH LEIDY, JR.—The fact that the man recognizes that these objects do not exist and presents no other evidences of insanity is against such an idea. In connection with Dr. Mitchell's remarks, I remember distinctly a patient as a neighbor at table at the Pennsylvania Hospital, a man who was perfectly sane upon every subject except one, that of uncleanliness. He had periodic attacks of melancholia. At other times, the mesaphœbia took the place of the insanity.

In this case, I think that until the visual fields have been examined and the question of anæsthesia determined in connection with any other symptoms, we should reserve a positive opinion, although it favors hysteria.

Dr. CHARLES K. MILLS.—This man may pass into a condition of true insanity. A patient may for a long time struggle against such hallucinations and finally come to believe in their reality. I remember the case of a man who for months had notions partly hallucinatory with which he struggled for a long time, feeling that they were not real, but at a certain time, which he described, he became convinced that he had been in error and that these were realities. From that time he continued to believe in them and out of a comparatively simple condition evolved a rather elaborate systematised delusion. Under the ordinary rules of diagnosis, Dr. Lloyd's position is well taken and this case could be better diagnosticated as hysteria than as anything else, but this fails fully to explain the case and fails to indicate with any certainty what the future of this man will be. We should do something in the way of treatment for this man. The strongest efforts should be made as the result of this consultation, by the physician in charge, and that it should be impressed on the patient, that his is a nervous affection that can be cured and that as a result of this consultation, means of cure have been decided upon. Then I think that it matters little what will be the exact method of treatment. Isolation, hydrotherapy, static electricity and metallic tonics would be of service.

Dr. G. BETTON MASSEY.—It seems to me that the diagnosis of hysteria is hardly tenable. In the similar instance referred to by Dr. Mills, it can be seen that the case was one of genuine hallucinations, originally, in which the intellection of the patient failed to be overcome. I think that I have seen such cases where ultimately, as the hallucinations increased, the disease producing the hallucinations increased, the intellect became affected and the patients finally believed that the hallucinations were real. This man tells us that he does not believe that these things are real, but he acts upon the belief that they are real more thoroughly than would be the case in hysteria. He is constantly going through motions which to my mind are more elaborate than mere hysterical conditions would produce, for it is rare that hysteria acts itself out thoroughly. It seems to me that the best interests of the man and his family would be subserved by considering this a case of threatened insanity, and treating it from that point of view.

Dr. F. X. DERCUM read a paper on

A CASE OF SYRINGOMYELIA WITH AUTOPSY.

DISCUSSION.

Dr. CHARLES W. BURR.—I made a few weeks ago a post-mortem in a case of syringomyelia in which there were no sensory changes. The man began sixteen years ago to have pain in the neck, very severe and soon after began to lose power in the arms and slightly in the legs with some wasting. Six years ago he came to the Home for Incurables with paralysis of arms and legs. Sensation to heat and cold was normal and there were no sensory changes when I last examined the man, a year ago. The absence of sensory changes made were put to one side the diagnosis of syringomyelia.

At the post-mortem examination, I found quite a large canal beginning in the uppermost part of the cervical region and extending down to the fifth dorsal nerve and transversely occupying almost the whole of the cord, but microscopically not appearing to involve the posterior white matter very much. There has not yet been time to make a microscopical examinaticn. The idea that sensory changes are an essential part of syringomyelia seems from this case to be misleading.

Dr. FRANCIS X. DERCUM.—The symptoms that would ensue would depend largely upon the portion of the cord destroyed. There would be muscular atrophy if the anterior portion was encroached upon. In this case there was no marked anterior wasting. I am sorry that in this case I did not make more detailed investigation of certain muscles and certain muscle groups. There was, however, no marked wasting anywhere. The cavity was accentuated posteriorly as it was also on one side.

The case was of interest on account of the marked contractures. I have now under observation a case where there is marked atrophy, distinct thermal changes and Charcot joints. In the case reported to-night there were also contractures of both arms and legs. The cavity was very large in the cervical region, cutting off both pyramidal tracts. The patient had in addition to the symptoms of syringomyelia, those of marked lateral sclerosis.

By Dr. JAMES HENDRIE LLOYD, read a paper on

PROGRESSIVE MUSCULAR ATROPHY WITH ARTHROPATHIES OF THE KNEE JOINT, (WITH EXHIBITION OF PHOTOGRAPHS OF THE HANDS AND KNEES.)

This case is of peculiar interest because it is one of pure muscular atrophy with arthropathies. The case came under my care at the Methodist Hospital where I found the woman suffering with enlargement of the knee joints. My predecessor and one of my surgical colleagues had tapped the joints. There was not the same lateral deviation as occurs in some cases. In this case, the attention had been directed almost exclusively to the knees. The moment that I saw her I was struck with the peculiar appearance of her hands. She had the main-en-griffe on each side. I found the arm muscles extensively atrophied, those on one side almost entirely gone. There was also scoliosis. I at first thought that the case was one of syringo-myelia and made suitable tests for sensation, but the results were negative. There was no thermal anæsthesia and no alteration of sensation in any way. I thought that I was not justified in making a diagnosis of syringomyelia. We have here the muscular, motor, atrophic, joint, and skeletal changes associated with syringomyelia, but not the sensory changes. I, therefore, report it as a case of progressive muscular atrophy associated with arthropathies. At the same time, I think that the association of spinal arthropathies gives the case a rather unique appearance and that the condition is probably due to some form of gliomatous change in the medulla spinalis.

In a former somewhat extensive study of the subject I found arthropathies reported as occurring in locomotor ataxia, general paresis, syringomyelia, and sclerosis in plaques. There are no cases recorded with progressive muscular atrophy, except one case reported by Rosenthal twenty years ago. That case, I think, was likely one of syringomyelia. The present case will be reported more fully in detail for publication.

Dr. FRANCIS X. DERCUM.—We are still in the developmental stage of our knowledge in regard to syringomyelia and it may be that in these joint changes we have a point of differential diagnosis between simple muscular atrophy due to chronic polio-myelitis and muscular atrophy due to syringomyelia. Of course, it is only by the study of many cases that we can gain any definite knowledge upon this subject.

Dr. F. SAVARY PEARCE reported

A CASE OF MULTIPLE NEURITIS SIMULATING LANDRY'S PARALYSIS, IN THE RAPIDITY, ORDER AND EXTENT OF PARALYSIS.

DISCUSSION.

Dr. CHARLES K. MILLS.—The question suggests itself whether the term neuritis as descriptive of this case is well chosen. Pain and sensory changes were not present, with the exception of slight tenderness in the popliteal space. The question occurs in connection with this case and other somewhat similar cases. Have we inflammatory disease of any type? Have we not really a form of toxic disease causing multiple degeneration, and should we not add to our nomenclature multiple degeneration of nerves instead of always speaking of multiple neuritis?

Dr. FRANCIS X. DERCUM.—I had an opportunity of studying this case during the summer and I was never absolutely certain in my own mind with regard to the diagnosis. I roughly grouped the case under the head of Landry's palsy, although in some respects it differed from the latter disease. It looked as though the trouble, possibly toxic, had affected not only the cord, but also the peripheral nerves—as though it were a mixed case. I remember that it was Dr. Mills who first called attention to these mixed cases of multiple neuritis with cord involvement.

Changes in the Ganglion Cell from Birth to Old Age.—Hodge (*American Therapist*, November, 1893). Hodge observed the difference in the first cervical ganglia of a fœtus at full term and of a man dying of old age at ninety-two. The ganglia were hardened in osmic acid and corrosive sublimate, embedded in paraffin and stained together on the slide.

The first difference to be noted between the ganglia is one of size, the ganglion of the old man being, by measurement, one hundred and five times larger in bulk than that of the fetus. This increase in size is seen from the sections to be due chiefly to sclerosis, the old ganglion consisting practically of a knot of connective tissue, in which are sparsely scattered small groups of nerve-cells and fibres.

In the cells themselves the most striking difference is the almost complete absence of nucleoli from the ganglion cells of the old man. Coupled with this is the extremely shrunken condition of the nuclei. The cells in this instance are largely filled with pigment and fat, both substances showing black in osmic acid specimens, the pigment being yellow and the fatty masses being represented by large vacuoles in sections by the corrosive sublimate method.

Careful measurements and estimates of pigment are given in tables. Similar changes are not found in the brain cells. J. C.